CITY OF SCOTTSDALE 2007/2008 ADDITIONAL DEPENDENTS

DEPENDENTS (LIST ALL DEPENDENTS TO BE ENROLLED)			
Dependent 5 Name (Last, First MI) ☐ Add ☐ Delete	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender
Dependent 1 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility # (if different from primary participant):			
Dependent 6 Name (Last, First MI) ☐ Add ☐ Delete	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender
Dependent 2 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #:			
Dependent 7 Name (Last, First MI) ☐ Add ☐ Delete	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender
Dependent 3 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility # (if different from primary participant):			
Dependent 8 Name (Last, First MI) ☐ Add ☐ Delete	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender
Dependent 4 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility # (if different from primary participant):			
Dependent 9 Name (Last, First MI) ☐ Add ☐ Delete	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender
Dependent 4 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility # (if different from primary participant):			
Dependent 10 Name (Last, First MI) ☐ Add ☐ Delete	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender
Dependent 4 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility # (if different from primary participant):			

AUTHORIZATION: By execution of this enrollment form, I understand that I may not change the election except in the event of a life change or during open enrollment. I authorize the City of Scottsdale to make the necessary before-tax and after-tax payroll deduction(s). I also understand that I am responsible for reimbursement to the City for any benefit amount paid to me/for me in advance of my payroll deduction. By my signature, I certify that the information on this form is true and correct, and that the listed dependents are my legal dependents.

☛Signature _____ Date _____

HR Signature_____ Date _____

***DOMESTIC PARTNERSHIP COVERAGE**

In addition to all other rules and conditions of city insurance coverage, the following apply to domestic partners coverage: In order for an enrollee to enroll a domestic partner for insurance coverage, both the enrollee and the domestic partner must complete the Domestic Partnership Affidavit. City of Scottsdale Human Resources must approve the affidavit prior to the commencement of coverage. Those with affidavits already on file do not have to resubmit. The portion of the insurance premium paid by the enrollee for domestic partner and children of the domestic partner is paid on an after-tax basis. The portion of the premium paid by the City for domestic partner and children of the domestic partner is reported to the Internal Revenue Service as taxable income to the enrollee. City enrollees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 30 days of the termination of the domestic partnership. Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage. To select or change Domestic Partner coverage, contact Lauran Beebe at 312-2746 or Debra Amado at 312-2429.

QUALIFIED LIFE STATUS CHANGES

You may not make changes to your benefit plans until the next open enrollment unless you experience a qualified life status change such as the birth of a child, marriage, divorce or satisfying the domestic partner eligibility. If you experience a qualified life status change, you may add or cancel dependents but you may not change plans. **You must notify HR within 30 days of a qualifying life status change. It is your responsibility to notify HR when a dependent (spouse/domestic partner or child) is no longer eligible for coverage.** Failure to cancel an ineligible dependent from your coverage within 30 days will make you responsible for any claims incurred by an ineligible dependent and may result in disciplinary action up to and including termination.